tissues in the vicinity of joints may be more obvious than arthritis, and sometimes median nerve entrapment gives rise to the carpal tunnel syndrome. The acute inflammatory appearance of the disorder makes gout and cellulitis possibilities in the differential diagnosis.

The relation of palindromic rheumatism to rheumatoid arthritis has long been debated. Ropes and Bauer[3] suggested in 1945 that some of the patients had rheumatoid arthritis and not palindromic rheumatism; Ward and Okihiro[4] found, in a five-year follow-up study, that as many as a third of 140 patients with palindromic rheumatism developed rheumatoid arthritis; Bywaters and Ansell[1] found that rheumatoid arthritis developed later in 30 of 66 patients. In each series there was wide variation in the duration of the palindromic phase—from months to many years. In two of these studies a few patients eventually developed systemic lupus erythematosus.

The sedimentation rate is often raised,[2] and a small proportion (though in one study[5] as many as 30%) of the patients have positive tests for rheumatoid factor in the serum. This finding, together with the clinical course, led to the view in the late 1960s that palindromic rheumatism was a state that could, for unknown reasons, develop into either rheumatoid arthritis or lupus erythematosus. Now there seems to be some doubt whether palindromic rheumatism is an entity at all; the 1970 edition of Copeman's textbook had a separate section on palindromic rheumatism[1] but not the 1978 edition, which appears to dismiss it as an early variant of rheumatoid arthritis.

Recently—and predictably in view of the surge of interest in diseases attributed to the formation and deposition of soluble immune complexes—there have been studies of serum complement components[5] and of immune complexes[6] in patients with palindromic rheumatism, including some who later developed rheumatoid arthritis. Patients showed no reduction in serum complement, a finding that would argue against palindromic rheumatism as predominantly an immune-complex disease. Similarly, immune complexes were found seldom—and only in patients with positive rheumatoid factor tests.

Palindromic rheumatism, then, is less a diagnosis than a label attached to a patient whose clinical state fits the description given above. The pathogenesis remains unknown. The prognosis seems to be strongly affected by the presence of rheumatoid factor in the blood; when this is present the diagnosis is probably best changed to rheumatoid arthritis. Management must rely on symptomatic treatment, for no prophylactic measures are available. The non-steroid anti-inflammatory drugs, particularly indomethacin or phenylbutazone, may suffice; but pain may be severe enough to require pethidine. Corticosteroids are usually to be avoided; but periodic short courses—say, two intramuscular injections of 80 mg methylprednisolone in depot form at three-day intervals—may be strikingly effective, and the risks of side effects seem negligible provided that the treatment is not repeated too frequently.

[1] Bywaters, E G L, and Ansell, B, in *Textbook of the Rheumatic Diseases*, 4th edn, ed W S C Copeman, p 524. Edinburgh and London, Livingstone, 1970.

[2] Hench, P S, and Rosenberg, E F, *Archives of Internal Medicine*, 1944, **73**, 293.

[3] Ropes, M W, and Bauer, W, *New England Journal of Medicine*, 1945, **233**, 592 and 618.

[4] Ward, L E, and Okihiro, M M, *AIR Archives of Interamerican Rheumatology*, 1959, **2**, 208.

[5] Wajed, M A, Brown, D L, and Currey, H L F, *Annals of the Rheumatic Diseases*, 1977, **36**, 56.

[6] Thompson, B, *et al*, *Annals of the Rheumatic Diseases*, 1979, **38**, 329.

Ludlow's preternatural bag

In an age in which diagnosis was confined to bedside observation and diagnostic accuracy could be verified only by post-mortem examination Abraham Ludlow, a Bristol surgeon, described "a case of obstructed deglutition from a preternatural dilatation of, and a bag formed in, the pharynx."[1] His account (in a letter to William Hunter written in 1764) was the first detailed description of the anatomy and pathophysiology of pharyngo-oesophageal diverticulum or pharyngeal pouch and antedated by 107 years Zenker's[2] description of the diverticulum which bears his name. Little can be added today to Ludlow's detailed clinical and anatomical description, beautifully illustrated by Jan van Rymsdyk's drawings,[3] of the postmortem specimen now in the pathological collection of Glasgow Royal Infirmary, and they form a splendid example of the way in which painstaking recording of symptoms and morbid anatomy can be applied to the art of clinical investigation.

Why diverticula should arise from the posterior pharyngeal wall immediately above the cricopharyngeus, which constitutes the upper oesophageal sphincter, is far from clear. Ludlow attributed it in his patient to a cherry stone lodging in the "loose holes which abound in the lower pharynx" and being forced outwards by swallowing through the anatomical weak spot, now known as Kilian's dehiscence,[4] between the lower borders of the inferior pharyngeal constrictors and the upper border of the cricopharyngeus. Since pharyngeal pouches seldom appear until late middle age, they seem unlikely to result simply from a congenital weakness.

Elsewhere in the alimentary tract diverticula are caused by motor incoordination causing high intraluminal pressures which force a pouch of mucosa through a weak spot in the muscle coat. This happens, for example, in oesophageal spasm and colonic diverticulosis. Originally achalasia of the cricopharyngeus was postulated to be the cause of pharyngeal pouch, but manometric studies have shown that the muscle relaxes during swallowing.[5] An association does exist between pharyngeal pouch and hiatus hernia with gastro-oesophageal reflux,[6] which increases the resting tone of the cricopharyngeal sphincter[7]—so reducing the risk of regurgitation into the mouth and respiratory tract. Even in these circumstances, however, the cricopharyngeus still relaxes adequately during swallowing. In patients with pharyngeal pouches what does seem to occur is a lack of co-ordination of the pharyngeal phase of swallowing with premature relaxation and closure of the cricopharyngeus. This has been shown both cineradiographically[8] and manometrically.[9] Closure of the cricopharyngeus while the pharyngeal constrictor muscles are still contracting and the oropharynx remains closed off generates transiently high pressures in the pharynx,[10] which might well extrude a mucosal pouch through Kilian's dehiscence. Such premature cricopharyngeal closure is present only in about half of the recorded swallows; presumably its pathogenesis is related to degenerative changes in the nerve supply.

Rational treatment for pharyngeal pouch should be based on understanding the underlying pathophysiological disorder. Small pouches may disappear after cricopharyngeal myotomy alone,[11] but this will not alleviate symptoms when a larger pouch is present. Apart from the risk of aspiration of the pouch contents into the respiratory tract, there is another hazard: carcinoma may arise in untreated pharyngeal pouches[12] and has been reported even after the Dohlman procedure of

division of the musculomembraneous septum between the pouch behind and the oesophagus in front.[13] These considerations heavily favour primary excision as the treatment of choice, but whether excision should be combined with cricopharyngeal myotomy to deal with the underlying disorder is less certain. After excision alone the pouch recurs in 15% of patients,[14] and recurrence is more likely in those with associated gastro-oesophageal reflux and hiatus hernia.[15] Whether myotomy is justifiable in these patients and whether it would reduce the recurrence rate remain matters for conjecture.

[1] Ludlow, A, quoted by Hunter, W, *Medical Observations and Inquiries*, 1767, **3**, 85.
[2] Zenker, F A, and von Ziemssen, H, *Handbuch des Speciellen Pathologie und Therapie*, vol 7. Leipzig, Vogel, 1877.
[3] Chitwood, W R, jun, *Surgery*, 1979, **85**, 549.
[4] Kilian, G, *Annales des Maladies de l'Oreille, du Larynx, du Nez, et du Pharynx*, 1908, **34** (2), 1.
[5] Kodicek, J, and Creamer, B, *Journal of Laryngology and Otology*, 1961, **75**, 406.
[6] Smiley, T B, Caves, P K, and Porter, D C, *Thorax*, 1970, **25**, 725.
[7] Hunt, P S, Connell, A M, and Smiley, T B, *Gut*, 1970, **11**, 303.
[8] Ardran, G M, Kemp, F H, and Lund, W S, *Journal of Laryngology and Otology*, 1964, **78**, 333.
[9] Ellis, F H, *et al*, *Annals of Surgery*, 1969, **170**, 340.
[10] Lichter, I, *Journal of Thoracic and Cardiovascular Surgery*, 1978, **76**, 272.
[11] Blakeley, W R, Garety, E J, and Smith, D E, *Archives of Surgery*, 1968, **96**, 745.
[12] Nanson, E M, *British Journal of Surgery*, 1976, **63**, 417.
[13] Juby, H B, *Journal of Laryngology and Otology*, 1969, **83**, 1067.
[14] Hansen, J B, *et al*, *Scandinavian Journal of Thoracic and Cardiovascular Surgery*, 1973, **7**, 81.
[15] Delahunty, J E, *et al*, *Laryngoscope*, 1971, **81**, 570.

When wild ideas make sense

"Doctors have tended to work in the past as if the NHS had access to a bottomless pit of resources." The paediatric consultant's indictment of the profession in the final interview of our series on NHS cuts (p 1570) is too true for comfort. Because doctors are responsible for spending much of the money available to the Health Service they must examine their own decisions critically, or others may do it for them. This was why the series' ten participants were deliberately cornered by the peremptory title: "If I was forced to cut." As the opening contestant, a community physician, frankly admitted of his own ideas, the plans for saving money varied from "the eminently practical to the rather wild." But today's wild ideas may be tomorrow's rational solutions and so should be studied as carefully as the more obvious economies suggested in the series—ranging from more efficient use of doctors' skills, simplifying administration, improving financial information, more careful prescribing habits, and reducing non-clinical jobs to having a best-buy guide for equipment and stopping overinvestigation.

Set against the scale of the present NHS financial squeeze many of the measures put forward in the series may seem trivial. Large overall savings can be made, however, by aggregating many small local economies. One area ripe for substantial economies is the servicing side of the NHS. Complaints about dirt and poor catering abound. One solution to these deficiencies is to farm out some non-medical services to private contractors. The NHS should not be regarded as a safety valve for Britain's unemployment problems. If certain jobs can be done more effectively and more cheaply by outside contractors, thus leaving more money for treating patients (an ideal supposedly supported by all NHS staff), then the proposal deserves serious consideration.

Whereas contracting out some services might provoke the wrath of some Health Service unions, the suggestion from the geriatrician for means testing long-stay patients would certainly cause wild words at Westminster. Yet his argument for doing so is persuasive and anyone disposed to dismiss it as a reincarnation of the Poor Law should think carefully about his words: "... Long-stay care in hospital is the most expensive form of treatment offered by the NHS. Although only 5-10% of patients referred ... ever require long-stay care, when they do it probably costs more for each patient than a heart transplant. If a person qualifies for care in a local authority residential home he will be financially assessed and will pay according to his means. A patient cared for long term in a geriatric hospital [except for a proportion of his pension] pays nothing, even if he is a millionaire." With the proportion of people over 75 still rising in Britain can we afford to ignore such a rational idea for a major economy?

Community health councils are still regarded with suspicion or opposed outright by many doctors. So the psychiatrist's idea that the councils should act as local financial watchdogs could well be classed as wild. Yet MPs have been struggling for years, with some recent success, to set up Parliamentary watchdogs on Whitehall's activities. Could not some parallel local system usefully discover the facts and figures on running the NHS? Nevertheless, we must enter two caveats on this possible innovation: firstly, the quality of CHC membership would need to be improved and, secondly, NHS budgeting methods should be more clearly explained.

The present hospital budgeting system was consistently attacked as frustrating and inefficient and one solution several doctors backed was introducing budgets for clinical teams. The idea that doctors would actually manage the budget might seem wild to some treasurers (but not to the community physician, who was confident that, provided any clinical team that managed its resources well benefited, the result would be good value for money). But, as the psychiatrist emphasised, any budgetary control by doctors must be effective so that they could really influence decisions in the NHS. A recent leading article in an administrators' journal[1] should encourage doctors to explore this unfamiliar territory. It declared: "Clinical autonomy is all too often taken to mean that doctors have a right to do what they want, paying scant attention to the cost implications of a new drug or the manpower implication of a new form of treatment.... Doctors must do their bit in deciding priorities and planning a service which makes the best use of available resources." Clearly many doctors would recoil from the potential conflict between their professional obligation to the patient—their clinical freedom to decide the best treatment—and the inability of their team budget to meet those obligations. The conflict was well illustrated by the paediatrician, who admitted: "At the moment I am almost schizoid in my thinking over finance. Although I recognise that money is tight and there is not enough to go around, when I am trying to get staff and equipment for my unit I fight tooth and nail and do not hesitate to make emotional references to babies dying because of inadequate equipment." This dilemma has to be resolved. Surely a team of doctors close to the patient would usually be better placed to decide such budgetary priorities than a remote committee.

[1] *Health and Social Service Journal*, 1979, **88**, 1533.